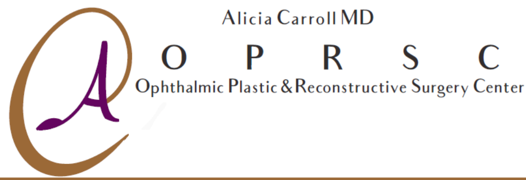


TEL: 828-267-2660 / FAX: 828-267-2661 / 2660 TATE BLVD SE STE 200 - HICKORY, NC 28602 / www.oprsc.com

Date: ____________________

Patient Name: _________________________________

Thank you for contacting Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center. We greatly appreciate your interest and look forward to meeting you and addressing your medical and/or cosmetic needs.

Enclosed, please find our new patient paperwork for you to complete (**ink** only) and do one of the following:

1- Bring with you to our office on the day of your appointment.
2- Fax to our office at 828-267-2661
3- Mail to our office at the address listed above.

This will benefit you as it shortens your wait in our reception area prior to seeing Dr. Carroll.

Please **bring with you** and **have ready:**

- **INSURANCE CARD**
- **PHOTO ID (DRIVER'S LICENSE)**
- **A LIST OF VITAMINS AND MEDICATIONS CURRENTLY TAKEN**

Sincerely,

The Staff of Alicia Carroll M.D.

Alicia Carroll MD
O P R S C
Ophthalmic Plastic & Reconstructive Surgery Center

TEL: 828-267-2660 / FAX: 828-267-2661 / 2660 TATE BLVD SE STE 200 - HICKORY, NC 28602 / www.oprsc.com

PATIENT INFORMATION

Patient Full Name: ______________________________ **Today's Date:** ________________________

Chart #: ________________ Driver's License #: ______________________________

Home Address: _________________________ **City:** _______________ **State:** ______ **Zip:** _______

Telephone: (____)____________ Cell Phone: (____)____________ Work Phone: (____)______________

Email Address: ____

Date of Birth: ______________ Age: ___________ Social Security Number: _______-_____-_______

Marital Status: (circle one) Single Married Partnered Divorced Widowed Separated

Employer: ______________________ Occupation: ______________________________________

Is this visit related to a worker's comp claim? (circle one) Yes No If so, Date of Accident: ______________

Worker's Comp contact person: __________________________ Phone: ____________________

Other Important Contact Information

Emergency Contact: _________________________________ Phone: _________________________

Family Doctor: ____________________________________ Phone: _________________________

Referring Doctor: __________________________________ Phone: _________________________

Referral Information

How did you hear about OPRSC? ____

Referred by: _________________________________ **Purpose of Visit:** _______________________

Insurance Information

Name of Primary Insurance Company: ____

Insured's Name: _________________________________ **Date of Birth:** _______________________

Social Security #: ____________________ **Policy/ID #:** _______________ **Group #:**_____________

Customer Service Phone Number: __________________________

Secondary Insurance Company: ______________________ Policy/ID #: __________________________

Group #: ______________________________

Insured's Name: ____________________ Policy/ID #: _________________ Group #: _____________

Customer Service Phone Number: ___________________________

The following information is required if your insurance is through parent, spouse, or
If someone other than patient is financially responsible.

Full Name: ________________________ Relationship to Patient: ____________________

Date of Birth: ________________________ Social Security Number: _____________________

Address: _____________________________ City: _____________ State: __________ Zip: ________

Telephone: (______)____________________ Employer: ______________________________

The notice of Privacy Practices and Patient's Rights at Alicia Carroll, MD Ophthalmic Plastic & Reconstructive Surgery Center has been given to me. I have read the policy and been given the opportunity to have my questions answered. Therefore, I authorize the release of any medical information necessary to process claims associated with my visits. In addition, I authorize payments for medical and/or surgical benefits to be paid directly at Alicia Carroll, MD Ophthalmic Plastic & Reconstructive Surgery Center. I understand the policy regarding filing of my insurance for reimbursement, but know that as a patient of Alicia Carroll, MD, I assume a personal obligation and responsibility for my account. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

Signature of Patient or Legal Guardian: ___________________________ Date: ____________________

Alicia Carroll MD
OPRSC
Ophthalmic Plastic & Reconstructive Surgery Center

TEL: 828-267-2660 / FAX: 828-267-2661 / 2660 TATE BLVD SE STE 200 - HICKORY, NC 28602 / www.oprsc.com

Date: ______________________ Date of Birth: ______________ Age: ________________________

Name: ________________________________ Date last seen: ______________________________

Pharmacy Name: ___________________________ Pharmacy Phone: ___________________________

Chief Complaint/ History: ____

____

MEDICAL AND SOCIAL HISTORY

Medical History: do you have/ have you had any of the following (if checked please indicate date)?

- ☐ Alcoholism __________________
- ☐ Anemia / Blood Disease ________
- ☐ Arthritis / Osteoporosis ________
- ☐ Bladder Problems _____________
- ☐ Cancer ______________________
- ☐ Breast Disease ________________
- ☐ Diabetes _____________________
- ☐ Depression ___________________
- ☐ Epilepsy / Neuro Disease _______
- ☐ Gall Bladder Disease ___________
- ☐ Heart Disease _________________
- ☐ High Blood Pressure ___________
- ☐ High Cholesterol ______________
- ☐ Jaundice / Hepatitis disease______
- ☐ Kidney _______________________
- ☐ Migraines _____________________
- ☐ Respiratory (lung) disease _______
- ☐ Skin Disease ___________________
- ☐ Thyroid Disease ________________
- ☐ Ulcers _________________________
- ☐ Others _________________________

____

Past Surgical History: Please list any surgeries/ operations you have had.

Date	Operation	Date	Operation

Family History Do any family members (blood relatives) have the following (if yes, please indicate relationship to you)?

- ☐ Alcoholism __________________
- ☐ Anemia / Blood Disease ________
- ☐ Arthritis / Osteoporosis ________
- ☐ Bladder Problems _____________
- ☐ Cancer ______________________
- ☐ Breast Disease ________________
- ☐ Diabetes _____________________
- ☐ Depression ___________________
- ☐ Epilepsy / Neuro Disease _______
- ☐ Gall Bladder Disease ___________
- ☐ Heart Disease _________________
- ☐ High Blood Pressure ___________
- ☐ High Cholesterol ______________
- ☐ Jaundice / Hepatitis disease______
- ☐ Kidney _______________________
- ☐ Migraines _____________________
- ☐ Respiratory (lung) disease _______
- ☐ Skin Disease ___________________
- ☐ Thyroid Disease ________________
- ☐ Ulcers _________________________
- ☐ Others _________________________

____

Social History Smoking Y N Alcohol Y N Drugs Y N

List Medications Taken Here:

____

____

____

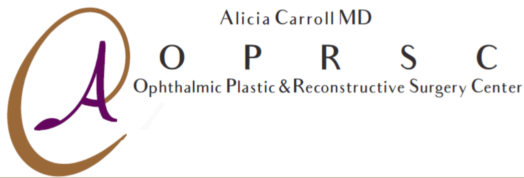
List Allergies Here:

____

____

____

Signature of Patient or Legal Guardian: ______________________________ Date: ________________



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CONTRACTED CARE CONSENT AND AUTHORIZATION FORM

Patient: ____ Responsible Party: __________________________________

Relationship: ____

Consent for Routine Treatment: I hereby consent to the rendering of medical care, which may include routine diagnostic procedures and such medical treatment as my physician or others at Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center consider necessary. I understand that:

- It is the policy of Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center that absent emergency or extraordinary circumstances, no substantial procedures are performed upon me unless and until I have an opportunity to discuss them with my physician or other healthcare professionals.
- I have the right to contest, or to refuse consent to any proposed procedure or therapeutic course.

Payment:

I/ We agree to pay all charges for medical care rendered by Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center and it's physicians to me, my spouse, and/or minor children.

I/We jointly and severally, guarantee full payment of all charges for medical care rendered by Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center and it's physicians to me, my spouse, and/or minor children, whether living with me or not. This is a guaranty of payment and not merely of collection, and I agree to be directly responsible for the payment of all charges incurred by these children.

If I/ We fail to pay such charges due to Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center and it becomes necessary for Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center to institute collection efforts against me/us, I/We agree to pay Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center all cost of collection thereof, including reasonable attorney's fees incurred in the connection therewith.

I/ We understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

Assignment of Insurance Benefits:

I hereby authorize payment directly to Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center of medical or surgical benefits otherwise payable to me, including major medical insurance. I understand that I am financially responsible in this event medical or surgical benefits exceed the charges of Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center for its serves in connection with the treatment rendered during this encounter. Any such excess amount may first be applied to payment of any other indebtedness due by me or my legal dependents for other treatment rendered and the balance, if any remains, shall be paid to me.

Authorization for release of medical information:

Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center and/or my physician is authorized to furnish any medical information relating to treatment to my insurance company, health maintenance organization, preferred provider organization, alternative delivery system governmental or charitable agencies and their agents, my employer, and professional review organization with whom I have an established relationship. I may revoke this authorization at any time, except to the extent that action has already been taken in reliance to this authorization prior to its revocation.

The notice of Privacy Practices and Patient's Rights at Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center has been given to me. I have read the policy and been given the opportunity to have my questions answered. Therefore, I authorize the release of any medical information necessary to process claims associated with my visits. In addition, I authorize payments for medical and/or surgical benefits to be paid directly to Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center. I understand the policy regarding filing of my insurance for reimbursement, but know that as a patient of Alicia Carroll, MD, I assume a personal obligation and responsibility for my account. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I have read and understand this authorization form, and agree to the provisions pertaining to my relationship with Alicia Carroll MD Ophthalmic Plastic & Reconstructive Surgery Center.

______________________	______________________	______________
Signature of Patient	Signature of Witness	Date
______________________	______________________	______________
Signature of Guardian	Signature of Witness	Date

Alicia Carroll MD
O P R S C
Ophthalmic Plastic & Reconstructive Surgery Center

TEL: 828-267-2660 / FAX: 828-267-2661 / 2660 TATE BLVD SE STE 200 - HICKORY, NC 28602 / www.oprsc.com

How May We Contact You?

Chart # ______________________________

Patient Name: ______________________________________ **Date of Birth** ______________________

Sometimes it is necessary to communicate with your clients regarding appointments, instruction and other information about treatments received at our practices. Oftentimes, it is not possible to reach you personally. In the event that we are not able to speak with you directly, please give us instructions regarding the best way to communicate with you.

Please check all that apply and complete the necessary information:

- ☐ Messages may be left on my home answering system. The number is ____________________________
- ☐ My answering machine does not identify me by name, but it is OK to leave message for me there anyway.
- ☐ Messages may be left for me at my work voicemail. The number is _____________________________
- ☐ Messages may be left at home with my partner. His/her name is: _______________________________
- ☐ Messages may be communicated to me via email. My email address is: __________________________
- ☐ Other persons authorized to receive messages on my behalf are:

_____________________________	_____________________________
Name	Contact Info
_____________________________	_____________________________
Name	Contact Info

I hereby release, discharge and agree to hold harmless all parties to whom the consent is given from any liability that may arise from the release of information to those authorized above. I understand that I may revoke this consent in writing at any time.

____

Patient Signature or Parent/Guardian Signature   Date

____

Relationship to Patient if Minor

Alicia Carroll MD
O P R S C
Ophthalmic Plastic & Reconstructive Surgery Center

TEL: 828-267-2660 / FAX: 828-267-2661 / 2660 TATE BLVD SE STE 200 - HICKORY, NC 28602 / www.oprsc.com

CONSENT/PERMISSION FOR USE OF PHOTOGRAPHS

I, ____, willingly and knowingly am allowing Dr. Carroll to photograph me, giving her permission to use my “before and after” photos. I understand that the photographs will be used as a marketing tool to promote her business, including, but not limited to: *Brochures, *Websites, *Press Releases, *Advertisements, *Lectures, *Seminars and to patients considering a surgical procedure. I further understand that I will not be identified by name and/or any identifying information will not be used in the photographs and I shall receive no compensation for the use of the photographs.

I DO HEREBY GIVE DR. CARROLL MY FULL PERMISSION TO USE IT AS SHE SEES FIT, IN ADDITION, I UNDERSTAND THAT AT ANY TIME I MAY NOTIFY DR. CARROLL IF I WISH FOR HER TO DISCONTINUE USE OF THESE IMAGES.

____ ____________________________
Signature Date

____ ____________________________
Printed Name Witness

ALL PHOTOGRAPHS ARE THE PROPERTY OF:
ALICIA M. CARROLL, M.D.
OPHTHALMIC PLASTIC AND RECONSTRUCTIVE SURGERY CENTER
LASER & AESTHETICS

PATIENT ACKNOWLEDGMENT AND CONSENT

For New Patients Only

I have been given a copy of Alicia Carroll M.D. Ophthalmic Plastic & Reconstructive Surgery Center, PLLC's Notice of Privacy Practices, version effective January 1st, 2017. I consent to the uses and disclosures of my health information as outlined in the Notice.

____ ____
Signature of Patient or Representative Date

____
Print Name

____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: ________________________________

____

____

FOR Alicia Carroll M.D. Ophthalmic Plastic & Reconstructive Surgery Center, PLLC USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgement and the reason you could not obtain it:

____

____

____

____

Alicia Carroll MD
O P R S C
Ophthalmic Plastic & Reconstructive Surgery Center
TEL: 828-267-2660 / FAX: 828-267-2661 / 2660 TATE BLVD SE STE 200 - HICKORY, NC 28602 / www.oprsc.com

Directions to Our Office

From **NC-16 N:** Take Nc-16 North through Denver, Lincolnton, Maiden, and Conover. In Conover, bear **Right** on NC-16 North then take I-40 **West**. Take I-40 West until you arrive at **Exit 126**. Take the exit, and then turn **Right** onto McDonald Parkway. Continue straight, then turn **right** at the 2nd light on Tate Blvd. Our office is the 1st building on the right (mirrored glass and brick building). We are on the 2nd floor @ OPRSC.

From **I-77:** Take I-77 until I-40 at Exit 51A. Merge onto I-40 **West** and take Exit 126. Turn **Right** onto McDonald Parkway, and then turn **Right** onto Tate Blvd at the intersection. Our office is the 1st building on the right (mirrored glass and brick building). We are on the 2nd floor @ OPRSC.

From **I-85S/321 N –** Take I-85 South until Exit 17 - 321 North. Merge onto 321 **North** and take Exit 43 for I-40. Merge onto I-40 East and take Exit 126. Turn **Left** onto McDonald Parkway, and then turn **Right** onto Tate Blvd at the intersection. Our office is the 1st building on the right (mirrored glass and brick building). We are on the 2nd floor @ OPRSC.

From **I-40:** Take I-40 until Exit 126. Turn **Right** (from I-40 **West**, **Left** from I-40 **East)** onto McDonald Parkway, then turn **Right** onto Tate Blvd at the intersection. Our office is the 1st building on the right (mirrored glass and brick building). We are on the 2nd floor @ OPRSC.